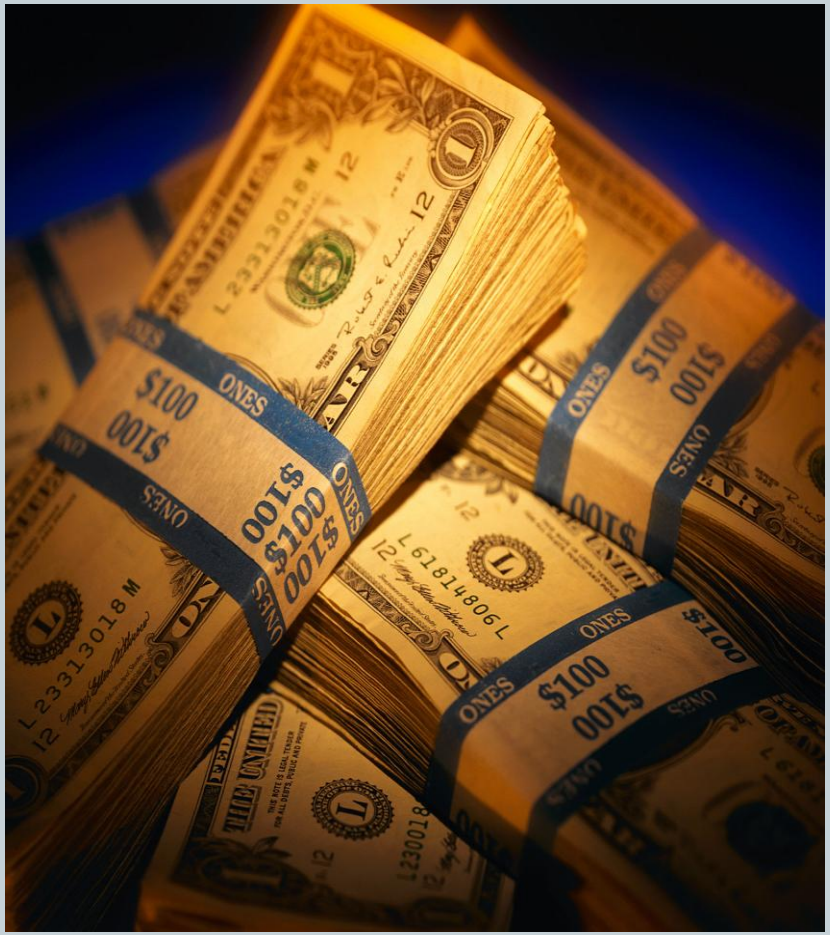
Arkansas Health Information Technology Task Force Meeting

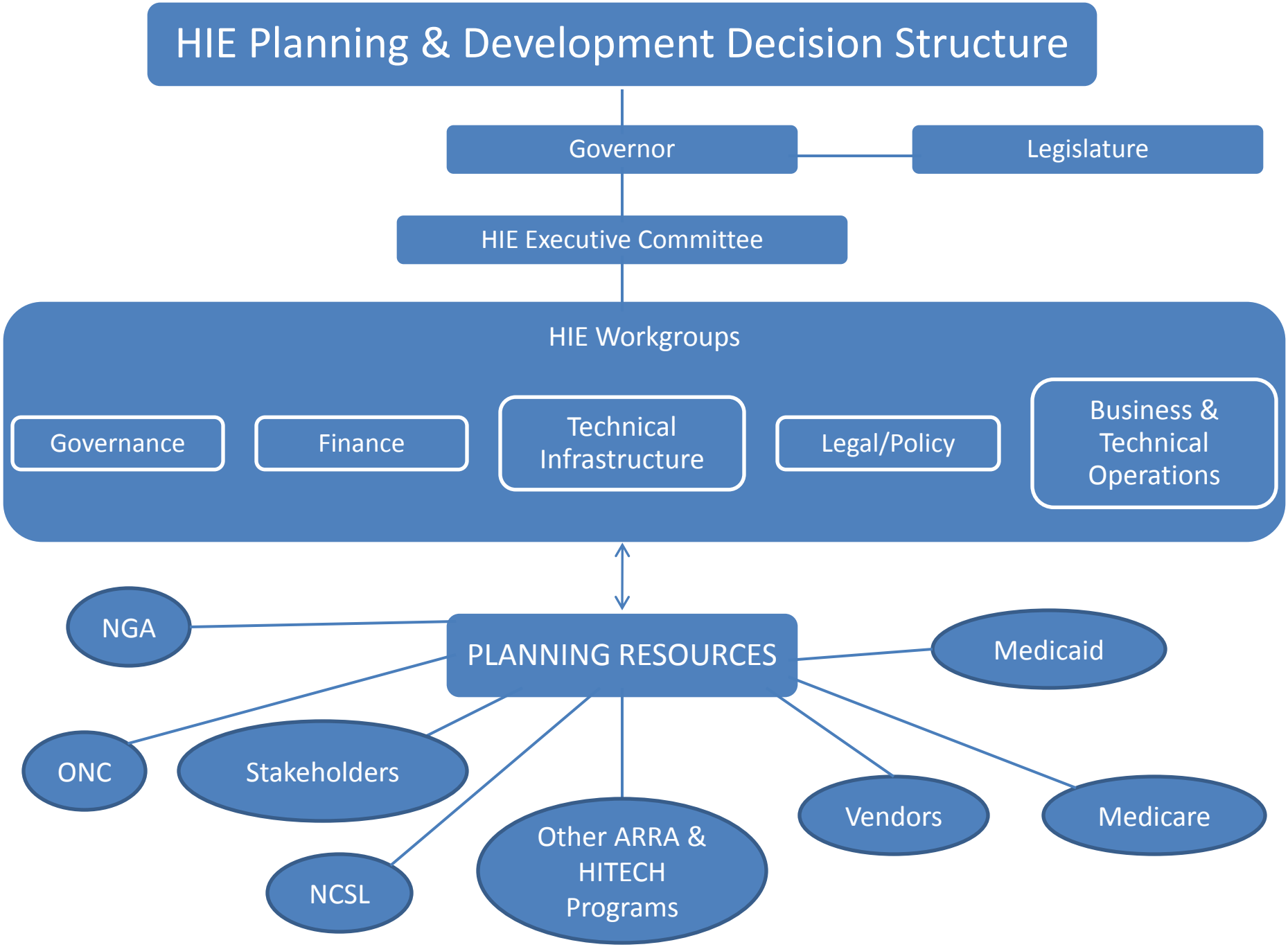
DR. JOSEPH THOMPSON
SURGEON GENERAL
MARCH 03, 2010
J.L. GILBREATH CONFERENCE CENTER
CONFERENCE ROOM 22
BAPTIST HEALTH
10:00 AM TO 12:00 PM

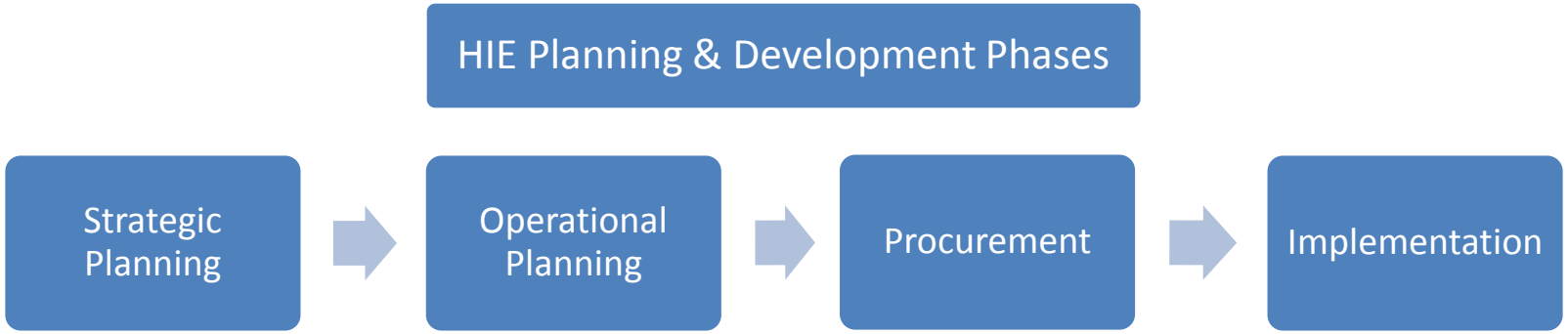
Funding Announcements

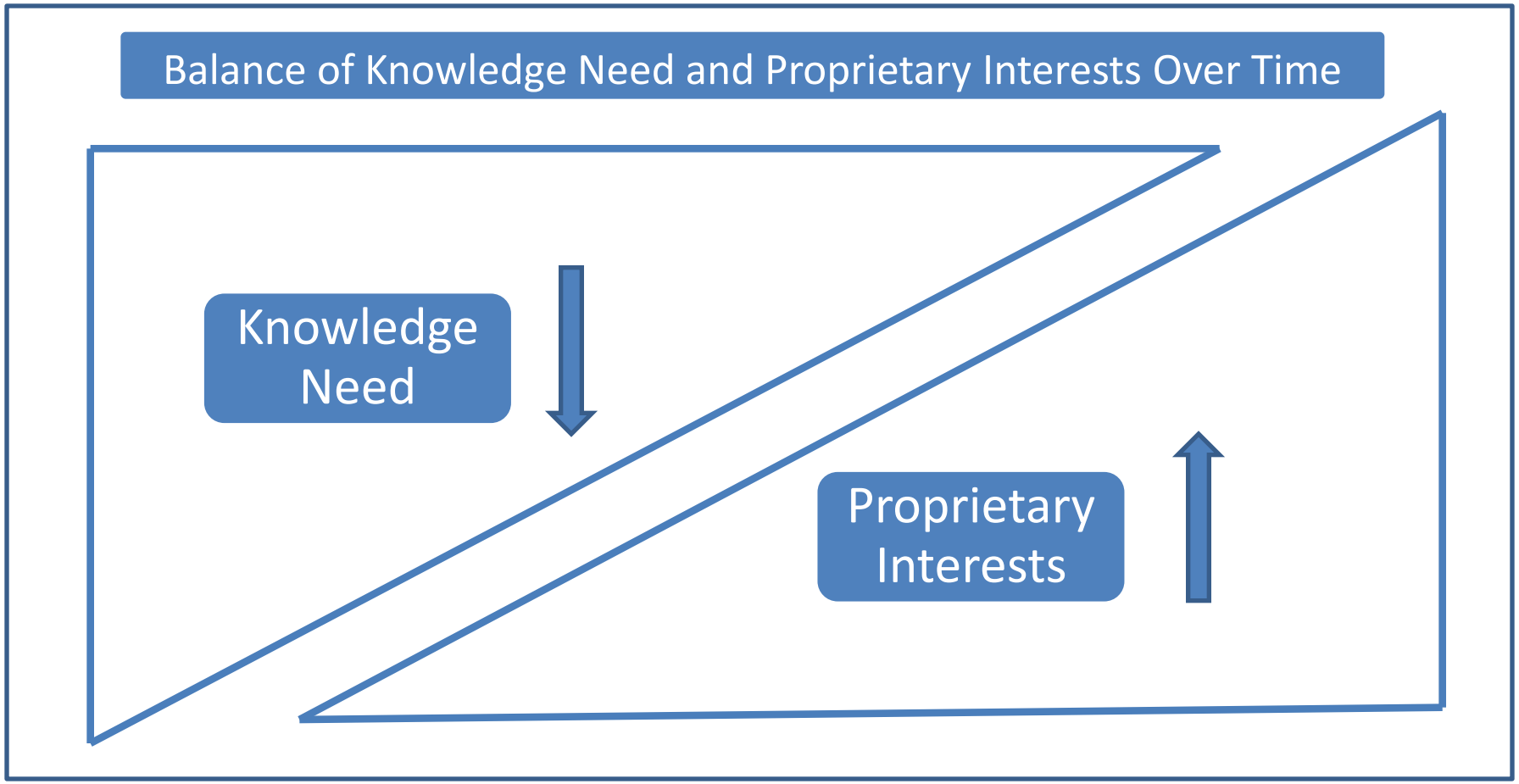
- REC: $ 7,400,000
- HIE: $ 7,909,401
- Other
- See http://www.hhs.gov/news/press/2010pres/02/20100212a.html for press release



Disclosure and Ethical Standards


HIE Planning & Development Decision Structure
Governor
Legislature
HIE Executive Committee
HIE Workgroups
Governance
Finance
Technical Infrastructure
Legal/Policy
Business & Technical Operations
NGA
PLANNING RESOURCES
Medicaid
ONC
Stakeholders
Vendors
Medicare
NCSL
Other ARRA & HITECH Programs


HIE Planning & Development Phases
Strategic Planning
Operational Planning
Procurement
Implementation


Balance of Knowledge Need and Proprietary Interests Over Time
Knowledge Need
Proprietary Interests

HIE Planning & Development Process Principles

Openness	Conduct meetings and other planning activities in public to achieve maximum feasible participation of stakeholders
Transparency	Fully disclose information, documents, and materials in an easily-accessible manner and fully disclose all participants' affiliations
Scope of Knowledge	Actively pursue and solicit information, knowledge, and expertise from a wide variety of resources
Unbiased Process	Create a level playing field by avoiding the pre-judgment of or exclusion of potential solutions, approaches, models or products for HIE development

Presentation Protocols

1. Both Co-Chairs should be available for presentations to EC if at all possible; where possible the co-chair representing the respective group should deliver the remarks with the other co-chair supporting and offering comment as appropriate
2. Each presentation should include:
    1. Short summation of the issue to be presented:
    2. List of information that will be or is being considered
    3. Where consensus and/or division is being expressed
    4. Options that will likely emerge in recommendations
3. Entertain questions from the members
4. Chair to entertain questions/opinions from members of the audience

Workgroup Status Updates

- Governance
  - Keith Vire & Paul Halverson
- Technical Infrastructure
  - David Matthews & John Ahlen
- Business and Technical Operations
  - George Platt & Kym Patterson
- Finance
  - Jason Lee & Randy Zook

Governance Workgroup

- Needs to be a phased governance model approach
- Phase 1 model will reflect what was submitted in the grant proposal
  - State led model with the creation of the Office of HIE and HIE Council
  - HIE Council will mirror the Executive Committee
  - HIT/HIE Forum
- Phase 2 will transition into a public utility type model
- Group is considering options for the structure of this phase 2 model and Board composition

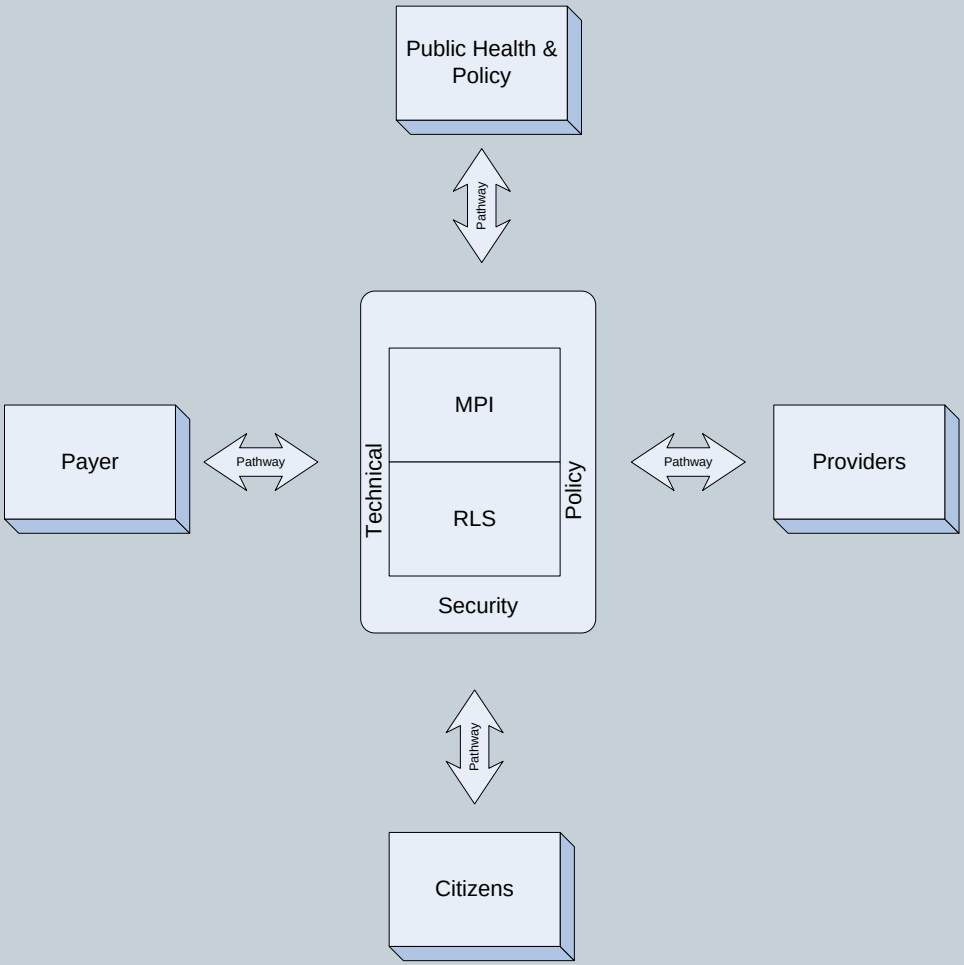
Technical Infrastructure Workgroup

- In its three meetings, we have introduced members of the work group, identified what we do and where we work. We have found that we have a very diverse group.

- We have worked on infrastructure requirements for an exchange; we have heard a presentation on meaningful use by Dr. David Matthews, who is co-chair of the workgroup.

- At our most recent meeting, there was a discussion led by representatives from Jefferson Regional Medical Center and UAMS, who are conducting a pilot project around the transfer of health records for patients who are transferred from Pine Bluff to Little Rock.

Business and Technical Operations Workgroup—Proposed Basic Health Information Exchange Business Model



Finance Workgroup

- Researched other states financing efforts:
  - Delaware
  - New York
  - Vermont
- Next meeting is Monday, we will be looking at Public/Private financing examples:
  - Connect Arkansas
  - Information Network of Arkansas
- Looked at Benefits of HIE
- Tracking in-kind hours by HIE Workgroups to assist with future matching opportunities
  - ONC specifically said that in-kind contributions can be counted towards our state match, so these hours could be very important when we get to the point when we need to provide matching
- Working with DF&A to create document delineating Reporting Requirements, Performance Requirements & Financial Controls for Cooperative Agreement

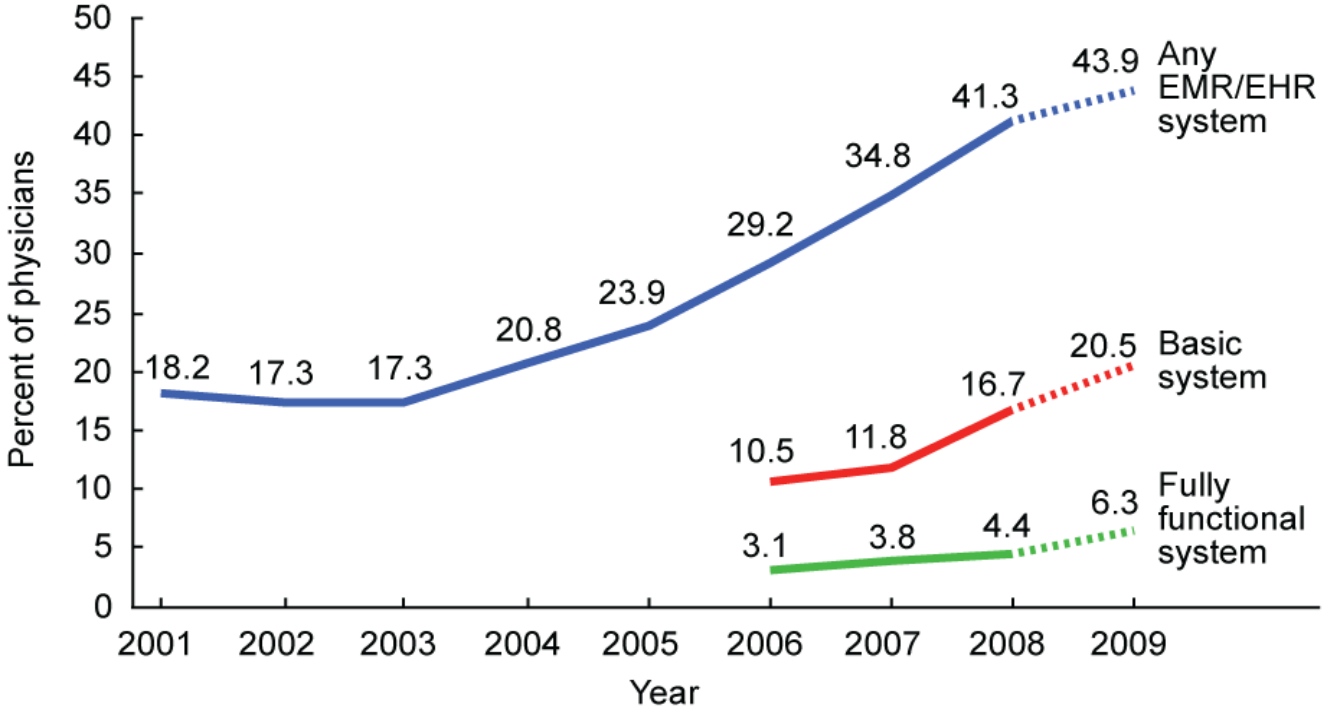
Meaningful Use: Overview of Stage 1 Criteria

Outline

- Current State of HIT Dissemination
- HITECH's Response
- Overview of Meaningful Use Stage 1 Criteria

The Current State of Affairs

Figure. Percentage of office-based physicians using electronic medical records/electronic health records (EMRs/EHRs): United States, 2001–2008 and preliminary 2009



NOTES: Any EMR/EHR is a medical or health record system that is either all or partially electronic (excluding systems solely for billing). The 2009 data are preliminary estimates (as shown on dashed lines), based only on the mail survey. Estimates of basic and fully functional systems prior to 2006 could not be computed because some items were not collected in the survey. Starting in 2007, the skip pattern after the all or partial EMR/EHR systems question was removed. Includes nonfederal, office-based physicians. Excludes radiologists, anesthesiologists, and pathologists.
SOURCE: CDC/NCHS, National Ambulatory Medical Care Survey.

Hospital adoption

- Hospitals (2008):
  - 10 percent basic.
  - 1.5 percent comprehensive.
  - Large percentages with pieces of EHR.

Source: DesRoches CM et al. Electronic health records in ambulatory care—a national survey of physicians. *N Engl J Med.* *359(1):50-60, 2008 Jul 3.*

Barriers HIT Adoption and Effective Use

- Market Failures
- Technology and Logistics
- Absent Platform for Exchange
- Privacy and Security Concerns

The Federal Government's Response: HITECH

- Establishes the revolutionary goal of **Meaningful Use.**
- Systematically addresses barriers to adoption:
  - Money/market reform
  - Technical assistance, support and better information
  - Health information exchange
  - Privacy and security

Provider Incentives—Market Reform

- Medicare and Medicaid Incentive Programs
  - Start in January, 2011
  - Max Incentives
    - Medicare - $44,000
    - Medicaid - $63,750
  - Can only be eligible for one program
  - Eligible professionals defined differently by program

Eligibility Requirements

- **Medicare Eligible Professionals**
  - a doctor of medicine or osteopathy
  - a doctor of dental surgery or dental medicine
  - a doctor of podiatric medicine
  - a doctor of optometry
  - a chiropractor
- **Medicaid Eligible Professionals**
  - Physician
  - Dentist
  - Certified nurse mid-wife
  - Nurse practitioner
  - Physician assistant (Rural health clinic or FQHC)
- **Non-Hospital Based**

Medicare Incentive Program

- Total Maximum Incentive $44,000
  - Year 1 - $15,000 ($18,000 in 2011 & 2012)
  - Year 2 - $12,000
  - Year 3 - $8,000
  - Year 4 - $4,000
  - Year 5 - $2,000
- The incentive increases by 10 percent if the provider is in an area designated as a health professional shortage area
  - Year 1 through 5 – Maximum of $48,400
- No incentives for providers adopting after 2014
- Penalties for non-adoption start in 2015

Medicare Provider Incentives by Adoption Year

Meaningful User	2009	2010	2011	2012	2013	2014	2015	2016	Total Incentive
2011			$ 18,000	$ 12,000	$ 8,000	$ 4,000	$ 2,000		$ 44,000
2012				$ 18,000	$ 12,000	$ 8,000	$ 4,000	$ 2,000	$ 44,000
2013					$ 15,000	$ 12,000	$ 8,000	$ 4,000	$39,000
2014						$ 12,000	$ 8,000	$ 4,000	$ 24,000
2015 +									$ Penalties

Medicaid Incentive Program

- Eligible professionals will receive 85% of the average allowable cost of implementing and using an electronic health record
  - Year 1 average allowable costs are capped at $25,000
  - Year 2 through 6 costs are capped at $10,000 each year
- Total Maximum Incentive - $63,750
  - Year 1 – Maximum of $21,250
  - Year 2 through 6 – Maximum of $8,500 each year
- The incentive amount is adjusted by two-thirds for pediatricians and children's hospitals
  - Year 1 through 6 – Maximum of $42,500
- No incentives for providers who adopt after 2016
- No penalties under the Medicaid Program

HITECH Response to Gaps in Technical Assistance, Technology, Human Resources

- $693 million
  - 70 Regional Extension Centers.
  - Health Information Technology Research Center.
- $564 million
  - Promote HIE through State leadership.
- $118 million
  - Training over 40,000 new personnel.

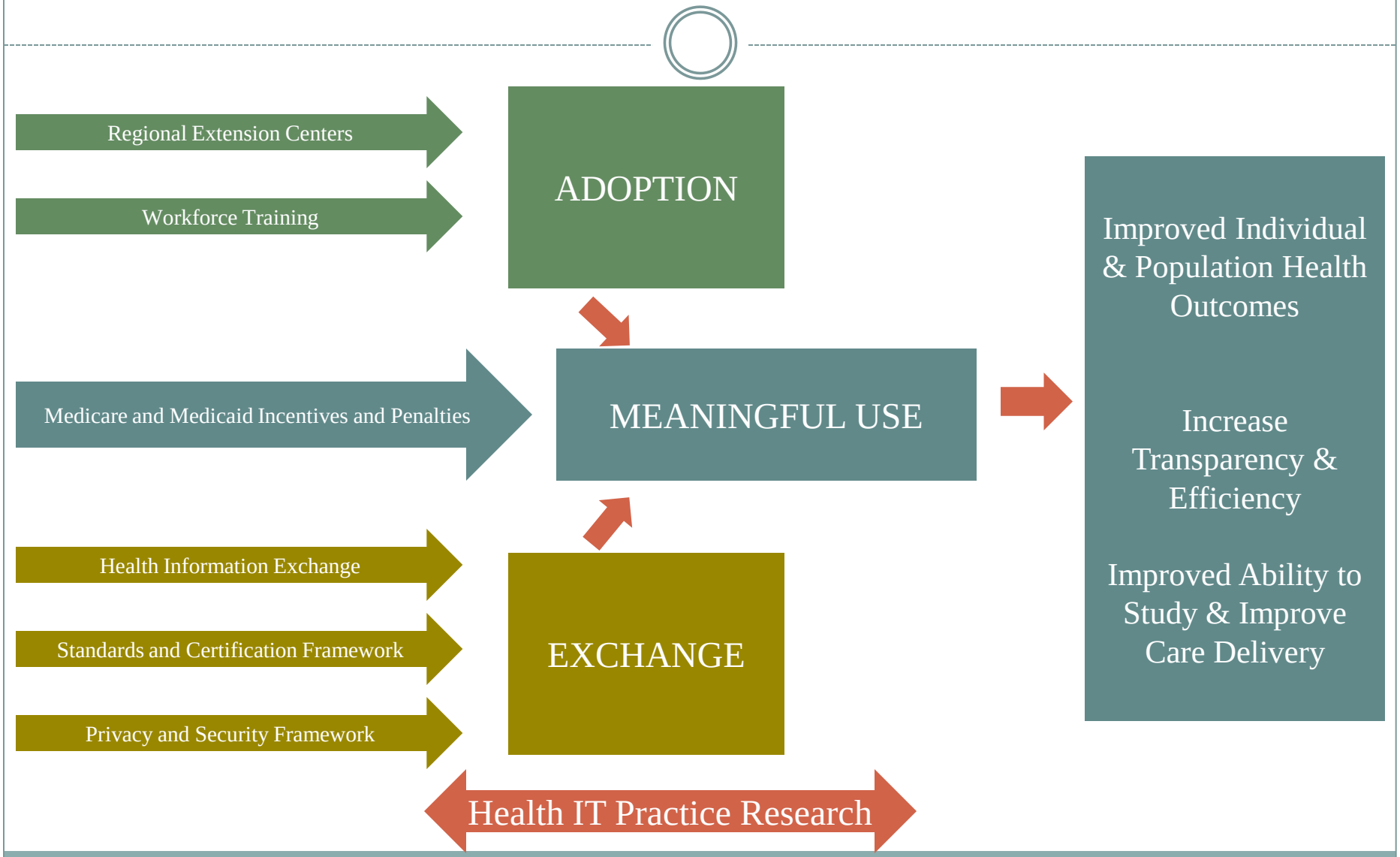
The Federal Government has Adopted a Solutions-Based Strategy

Obstacle	Intervention	Funds Allocated
Financial Resources	Medicare and Medicaid Incentive Program for "Meaningful Use."	$27 B*
Technical Assistance	Regional Extension Centers	$643 M
Human Resources	Workforce Training Programs	$118 M
Information Sharing	National Health Information Network & Standards and Certification	$64.3 M
Exchange	Health Information Exchange	$564 M
Technology	Strategic Health Information Technology Advance Research Projects	$60 M
Breakthrough Examples	Beacon Communities Program	$235 M

Source: US Department of Health & Human Services – ONC.

Meaningful Use Stage 1 Criteria

HITECH FRAMEWORK: MEANINGFUL USE AT CORE



Source: US Department of Health & Human Services – ONC.

Status and Size of Regulations

- Released as a Notice of Proposed Rule Making (NPRM) for public comment on December 30, 2009.
- 556-page document was posted officially in the Federal Register on January 13, 2010, and includes a 60-day comment period.
- Final rule is anticipated by late Spring to allow hospitals to prepare for their incentive program in October 2010 and providers to prepare for their program in January 2011.

Meaningful Use in Practice

Stage 1 – 2011	Stage 2 – 2013	Stage 3 – 2015
● Electronically capturing health information in a coded format ● Using that information to tract key clinical conditions ● Communication that information for care coordination purposes ● Initiating the reporting of clinical quality measures and public health information.	● Disease management ● Clinical decision support ● Medication management ● Support for patient access to their health information ● Quality measurement and research ● Bi-directional communication with public health agencies.	● Improvements in quality, safety and efficiency ● Decision support for national high priority conditions ● Access to self management tools ● Access to comprehensive patient data, and improving population health outcomes.

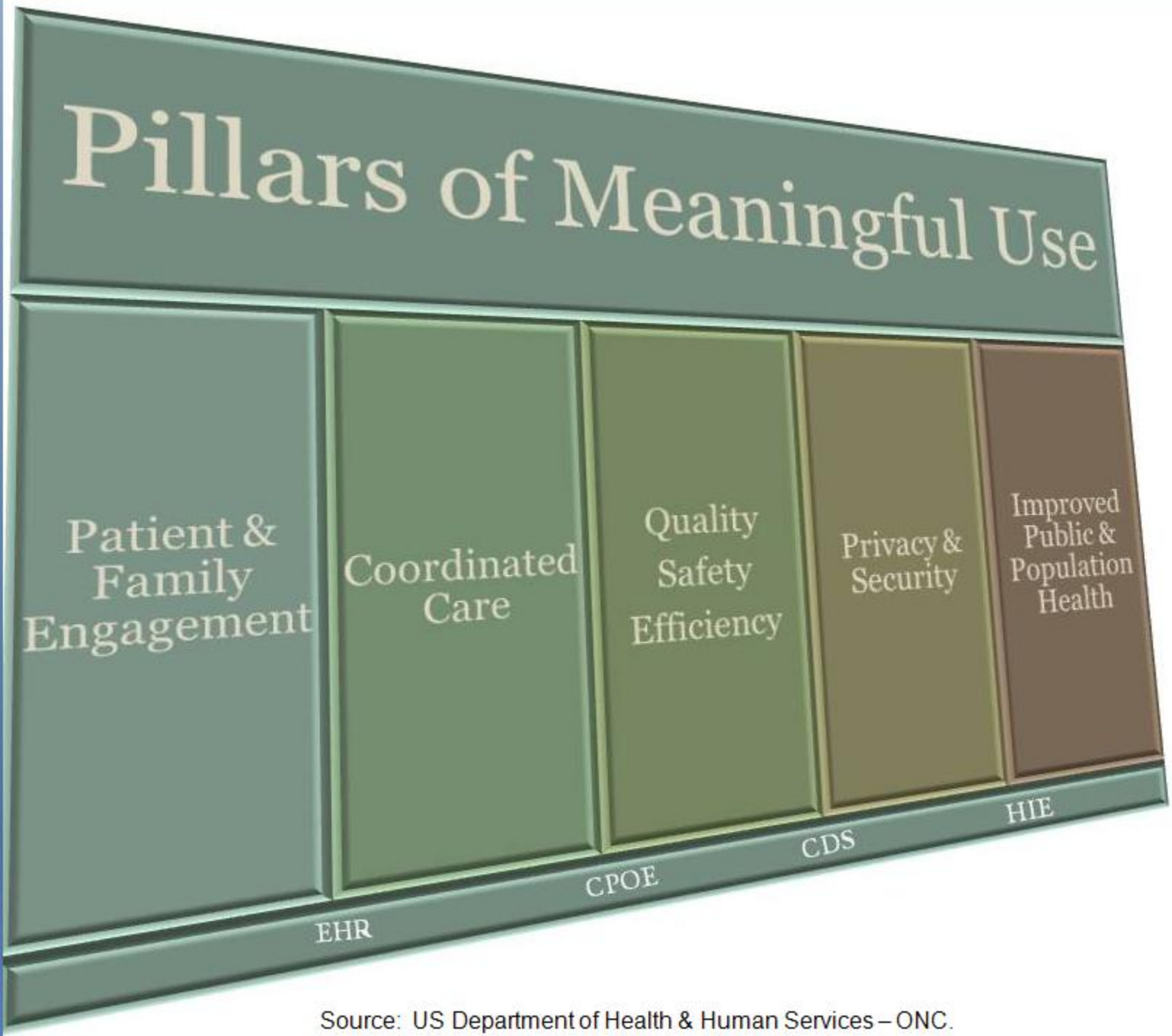
Source: US Department of Health & Human Services – ONC.

Stages of Meaningful Use Timeline

First Payment Year	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015 and later**
2011	Stage 1	Stage 1	Stage 2	Stage 2	Stage 3
2012		Stage 1	Stage 1	Stage 2	Stage 3
2013			Stage 1	Stage 2	Stage 3
2014				Stage 1	Stage 3
2015 and later*					Stage 3

*Avoids payment adjustments only for EPs in Medicare EHR Incentive Program
**Stage 3 criteria of meaningful use or a subsequent update to criteria if one is established.

Source: US Department of Health & Human Services – ONC.



Source: US Department of Health & Human Services – ONC.

Stage 1 Health Outcomes Policy Priorities

1. Improving quality, safety, efficiency, and reducing health disparities
2. Engage patients and families in their health care
3. Improve care coordination
4. Improve population and public health
5. Ensure adequate privacy and security protections for personal health information

1. Improving quality, safety, efficiency, and reducing health disparities

Care Goals:

1. Provide access to comprehensive patient health data for patient's health care team
2. Use evidence-based order sets and CPOE
3. Apply clinical decision support at the point of care
4. Generate lists of patients who need care and use them to reach out to patients
5. Report information for quality improvement and public reporting

1. Improving quality, safety, efficiency, and reducing health disparities

<u>Sampling of Stage 1 Measures in this priority:</u>

1. For eligible professionals (EP's), CPOE is used for at least 80% of all orders.
2. At least 75% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.
3. At least 80% of all claims filed electronically by the EP.
4. Report ambulatory quality measures to CMS or states. (**See next 2 slides**)
5. Implement 5 clinical decision support rules relevant to the clinical quality measures.

1. Improving quality, safety, efficiency, and reducing health disparities

Core Quality Measures for Eligible Professionals – 2011:

- Preventive care and screening:
  - Inquiry regarding tobacco use
- Blood pressure management
- Drugs to be avoided by the elderly:
  - Patients who receive at least one drug to be avoided
  - Patients who receive at least two different drugs to be avoided

1. Improving quality, safety, efficiency, and reducing health disparities

Different Quality Measures for the following Specialties:

Must select a specialty	
Cardiology	Psychiatry
Obstetrics and Gynecology	Ophthalmology
Pulmonology	Proceduralist/Surgery
Neurology	Podiatry
Endocrinology	Primary Care
Oncology	Radiology
Pediatrics	Gastroenterology
Nephrology	

2. Engage patients and families in their health care

<u>Care Goal:</u>

1. Provide patients and families with timely access to data, knowledge, and tools to make informed decisions and to manage their health.

2. Engage patients and families in their health care

<u>Stage 1 Measures in this priority:</u>

1. At least 80% of all patients who request an electronic copy of their health information are provided it within 48 hours
2. At least 10% of all unique patients seen by the EP are provided timely electronic access to their health information
3. Clinical summaries are provided for at least 80% of all office visits

3. Improve care coordination

<u>Care Goal:</u>

1. Exchange meaningful clinical information among professional health care team.

3. Improve care coordination

Stage 1 Measures in this priority:

1. Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information
2. Perform medication reconciliation for at least 80% of relevant encounters and transitions of care
3. Provide summary of care record for at least 80% of transitions of care and referrals

4. Improve population and public health

<u>Care Goal:</u>

1. Communicate with public health agencies

4. Improve population and public health

Stage 1 Measures in this priority:

1. Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries
2. Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically)

5. Ensure adequate privacy and security protections for personal health information

Care Goals:

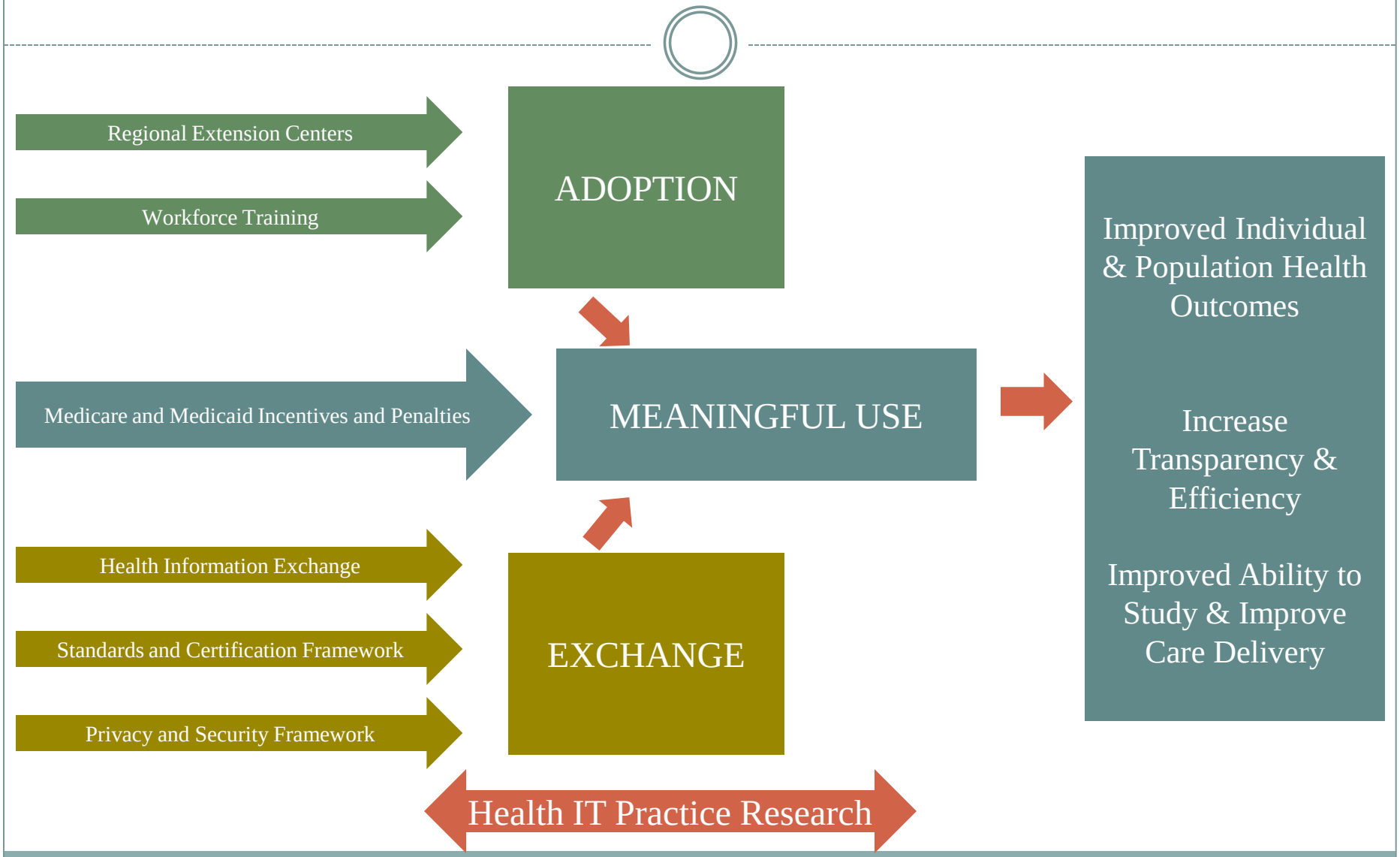
1. Ensure privacy and security protections for confidential information through operating policies, procedures, and technologies and compliance with applicable law.
2. Provide transparency of data sharing to patient.

5. Ensure adequate privacy and security protections for personal health information

Stage 1 Measures in this priority:

1. Conduct or review a security risk analysis and implement security updates as necessary

HITECH FRAMEWORK: MEANINGFUL USE AT CORE



Source: US Department of Health & Human Services – ONC.

Discussion

1. How does the HIE effort directly tie into the providers' achievement of meaningful use?
2. What entities need to be connected into the HIE to help providers achieve meaningful use?
3. What data is currently unavailable (or not transmitted), but is needed to meet meaningful use through the HIE?

Announcement of the HIE System Name:

- SHARE—State Health Alliance for Records Exchange